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SUICIDE IN DOCTORS

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Ireland's Suicide Prevention Strategy

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Suicide in Healthcare workers

Suicide in doctors, dentists, nurses, vets and others

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Between 1991 and 2000 indicated that doctors, dentists, nurses, vets and others were at increased risk of suicide. ONS -

- Office for National Statistics (ONS) data on occupational mortality in England and Wales Agerbo et al, 2007; Kelly and Bunting, 1998; Kõlves and De Leo, 2013; McIntosh et al, 2016and Meltzer et al, 2008).

Common explanations for the high risk of suicide in occupations like these include:

having easy access and knowledge of lethal drugs

- Hawton et al, 2000; Milner et al, 2016 and Skegg, 2010)

- https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/suicidebyoccupation/england2011to2015

Male Health Professionals- A changing picture

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•**Male doctors** are at high risk of suicide when looking at the PMR (PMR = 185). However, this finding conflicts with the SMR,

•which indicates that the risk of suicide among male doctors is low

•**The most recent UK data show** In the period between 2011 and 2015 they experienced a 16% reduced risk of suicide relative to the national average particularly seen among medical practitioners (37% lower).

Depression was more common in suicide of the medical doctors

Work problems were most prevalent in medical doctors @ 18.5%

Retired colleagues also warrant special care. The numbers for Ireland are not known.

(PMR used when base population characteristics not known)

•These findings are in keeping with past national and international research showing lower incidence of suicide among **male** health professionals (see Hawton et al, 2001and Kõlves and De Leo, 2013).

Female Doctors

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UK data, Meltzer et al (2008) found a **higher incidence of suicide among female health professionals**. In the UK, the suicide rate between 2011 and 2015 for all female health care professionals was higher than national average (ONS, 2017).

The suicide **risk for female doctors is a particular problem**. The female medical doctors had significantly higher rates than those of the education professionals, but were similar to those of the general population.

- Queensland 2013 www.ncbi.nlm.nih.gov/pubmed/24177487

A higher suicide rate in female versus male doctors was also found in 79 doctor suicides in Australia between 2001 and 2012

- (Milner et al, 2016). https://www.mja.com.au/journal/2016/205/6/suicide-health-professionals-retrospective-mortality-study-australia-2001-2012

However, more **recent data from Australia** has indicated that the suicide **rate may be rising** in **both male and female** doctors, to such an extent that both genders may have a greater suicide rate than the general population,

with a disproportionately higher risk in females (146% elevated risk compared with the general population for female doctors versus 26% for male doctors) (Blue Beyond, 2017).

- https://bhma.org/wp-content/uploads/2017/08/14.2.7-Dying-to-help.pdf

Risk for Psychiatrists?

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The suicide rate among psychiatrists revisited

Found there no evidence that the rates of any medical specialty are above average, controlling for the relevant variables

Suicide Life Threat Behav. 1979 Winter;9(4):219-26

Haughton et al found four specialties had suicide rates significantly higher than general medicine.

In order of risk these were **community health, anaesthetics, psychiatry and general practice.**

http://jech.bmj.com/content/55/5/296

Psychiatry **5th /27** in happiness

- Medscape survey

Specialty		
Anaesthetics	−5.2 (−7.1 to −2.9)	<0.001
Public health	+5.1 (2.7 to 7.9)	<0.001
Psychiatry	−3.8 (−5.8 to −1.8)	<0.001
Radiology	−3.5 (−6.5 to −0.5)	<0.05
Paediatrics	−2.6 (−5.1 to −0.1)	<0.05
Obstetrics and gynaecology	+3.1 (0.4 to 5.8)	<0.05
Laboratory	+2.3 (0.2 to 4.3)	<0.05

Medical Students

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- After accidents, suicide is the most common cause of death among medical students.
  - In one study, 9.4% of fourth-year medical students and interns reported having suicidal thoughts in the previous two weeks. [6]
- Prospective medical students and residents are extremely unlikely to report a history of depression
  - The prevalence of depression is unknown, but it is estimated to range from 15-30%. [5,6, 7, 8, 9, 52]
    - https://emedicine.medscape.com/article/806779-overview

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Healthcare Work

a Hazardous Occupation

‘depression, burnout, and suicide’

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The Association of American Medical Colleges July 2016 convened a meeting to address an escalating crisis of depression, burnout, and suicide among physicians..

AAMC
Tomorrow’s Doctors, Tomorrow’s Cures®

Recent Suicides Highlight Need To Address Depression In Medical Students And Residents’.

- ***JAMA* 312.17 (2014): 1725. Web. 29 Apr. 2015**.

JAMA®
The Journal of the American Medical Association

Suicide among health-care workers: time to act

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07 January 2017

The rate of depressive disorders among health-care workers compared with the general population (more than double) is alarming.

This crisis is not confined to the UK. 400 physician suicides per year in the USA,

A collaborative platform, aims to assess and understand the underlying causes of clinician burnout and suicide.

Healthcare in Ireland

One-third of doctors in Irish hospitals suffering burnout

IMO conference told burnout is most likely for young women doctors working long hours

Sat, Apr 7, 2018, 01:00

Martin Wall in Killarney

‘female, young, experiencing low job satisfaction and long working hours.’

Extraordinary
The chief executive of the RCPI Leo Kearns asked if this was an airline and one-third of the pilots were suffering from burnout, *“how safe would people feel about getting on to the plane?*

THE IRISH TIMES

Tue, Feb 7, 2017

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Study finds high rate of suicide among women in health sector

More than a quarter of women who took their own lives in Cork worked in health care

Sun, Oct 16, 2016, 23:35

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Tags # ASSOCIATION OF MEDICAL STUDENTS IRELAND # BURNOUT # DOCTORS

Depression, stress and emigration: Why medical students need to talk about mental health

A new campaign is aiming to take away the stigma some people feel about discussing issues such as depression and suicide.

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The contributing factors

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Changes in Healthcare &

Workplace stress

Medical work is changing

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- Workplace bullying, subject to constant scrutiny and oversight.
- Recording and form filling, incident reporting
- audit and review burdens
- Safety and quality obligations
- Regulatory burden
- Legal penalties
- external investigation
- complaint investigation,

without any reduction in clinical case load.

'Screen time' is the new saboteur of medical satisfaction.
Overwork is not the solution.

Doctor's work

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- Pressures greatest for those in frontline provision,
  - especially those undertaking post-graduate training
  - For instance, the study on resident deaths found 74 percent of suicides occurred during the first two years.
- Ever changing expectations,
- Encroachment of bureaucratic and business processes in work.
- An immersion in human suffering
- Difficulty in coping with patient's needs
- Long work hours. High expectations.
- A dread of making mistakes.

- EWTD +- a trade-off in regard to
  - fulfilment, depth and ease of training, and contact time with patients

Occupation specific hazards

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Personal financial difficulties

- including income pressures or mounting professional debts are difficult to reduce without adding further to the work burden.

- Strain on personal relationships also take their toll.
- Doctors at job transition points are especially exposed.
  - Authors also found that most resident suicides took place during the months of July to September and January to March

- Career progression obstacles,
  - short and long term are also significant, add to insecurity,
  - Amplify a sense of jeopardy,
  - trapping stressed doctors in unhealthy working predicaments.

Being the subject of a complaint

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One study found a majority experienced

- feelings of anger and depression,
- reduced levels of enjoyment in clinical practice,
- as well as feelings of guilt and/or shame

Being professionally ‘wounded’ by professional circumstance

or being in a point of personal vulnerability can inhibit and impair the compassion response.

Burnout and compassion fatigue

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- Prevalence now of ‘burnout’ as well as ‘compassion fatigue’ is a major concern for the healthcare sector,
  - given the impact it has on absenteeism, health of the professional involved and cost to the system,
  - without even beginning to quantify the costs in terms of safety, good practices and better outcomes for patients.

- Detachment, resentment and emotional numbing may result.
- A sense of helplessness, loss of perspective and pervasive professional negativity often follow.
- Professional self-doubt or loss of trust in colleagues are not easy burdens to share.
- Increased professional alienation from patients and the protection that goes with this, worsening the problem.

- tricky to recognise in one’s self.
- The specific interventions required to optimise outcomes need to be more available,
  Many who are clearly not clinically depressed but with severe burnout who are suicidal - *significant and remediable suicide risk in a colleague*.

Working with troubled patients

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Projective counter-identification - where the therapist unwittingly assumes the feelings and role of the patient

& moves a step beyond the therapist receiving the patient's projections without acting on them.[24]

where he acts out within the therapy this assumed role that has been projected into him,

Such a distortion of empathy arising from a part of the analyst's ego identifying with a part of the patient's ego,

causing the analyst to no longer observe the patient with the necessary analytic attitude.

This is not consciously perceived by the analyst, who consequently is 'led' by it.

https://doi.org/10.1192/apt.6.1.57

Doctors under investigation or ’in trouble’

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Fitness to Practice

Incident investigation, employer or collegial disputes,

Police investigation, and litigation
either while working or under suspension.

Even when resolved, they cast a long shadow, even on ‘re-entry’

This experience is especially difficult and dangerously isolating for those involved.

A further dimension is the concept of **multiple jeopardy.**

This is where a doctor maybe the subject of parallel investigation processes involving the employer, regulator, police, courts, patient or family interests or even a colleague.

A gap in indemnity cover is a further cause of regret.

- The GMC reported on 28 suicides over 8 years of doctors before the Fitness to Practice Committe and made valuable reccomendations which have been noted and taken up .

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Common Mental Health Problems in Doctors

Common mental disorders in the profession

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Doctors are no more likely or no less likely to experience the common difficulties of **depression, anxiety, bipolar disorder and substance misuse.**

Sleep deprivation is common.

Depression in high functioning individuals like doctors is easy to partially compensate for in work settings, making it harder to diagnose, easily missed

Many doctors to have a pessimistic expectation of their own recovery.

https://doi.org/10.1192/apt.3.5.251

The danger for us.....

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is that sole focus on the external pressures,
even when justified,

blinds us from seeing our illness

and taking the necessary steps

we may need to take for our wellbeing.

the literature emphasises

the need for doctors to also look to our own makeup and behaviour

A pathway we should fully understand

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The causal chain begins with:
Events that fall severely **short of standards** and expectations.
Failures are attributed internally,
which makes **self-awareness painful**.

Awareness of the self's inadequacies generates **negative affect**,
and the individual therefore **desires to escape** from self-awareness and the associated pain

The person enters a state of **cognitive restriction,**
narrows temporal focus, concrete thinking,
a focus on immediate or proximal goals,
rigidity, and rejection of meaning,

which **prevents meaningful self-awareness and emotion**.

The **deconstructed state brings irrationality** and disinhibition, making drastic measures seem acceptable. Suicide can be seen as an ultimate step in the effort to escape from self and world.

Roy F. Baumeister Case Western Reserve University Suicide as escape from aversive self-awareness.

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The ‘Psychology’ of Doctors

Culture and coping

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Starts in training school
pressure to master an overwhelming amount of material. Competition with peers can be brutal.
And students can face withering criticism from faculty who have poor tolerance for ignorance, signs of weakness, or emotional displays.

'Medical' character traits of individualism, competitiveness, ambition, being driven and inflexibility make vulnerability very threatening.

Temperamentally over-conscientious or under-conscientious pose unique difficulties

This is of course compounded by fear of discovery, fear of consequence, including consequences to work security and professional standing.

A training question? Sir William Osler.

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In his 1912 essay, “Aequanimitas,” Osler argues that by neutralizing their emotions to the point that they feel nothing in response to suffering, physicians can “see into” and hence “study” the patient's “inner life.”[6]

The concept of a detached physician accurately viewing a patient's emotions persists throughout the twentieth century. In their classic 1963 article, “Training for Detached Concern,”Fox and Lief describe how

physicians believe that the same detachment that enables medical students to dissect a cadaver without disgust

allows them to listen empathically without becoming emotionally involved.[7]

Viewers stand apart from what they observe. This contrasts markedly with the ordinary meaning of empathy as “feeling into” or being moved by another's suffering.

‘Emotional Labour’

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Healthcare education and training
can be “a profoundly dehumanizing experience

not all doctors are equally able to handle human distress
or at all points in their professional lives.

Doctors in distress themselves are particularly likely to find it difficult in dealing with patient’s needs,

....but more sensitive colleagues are often the most vulnerable of all.

A point to ponder…….mmmmm.. Maybe

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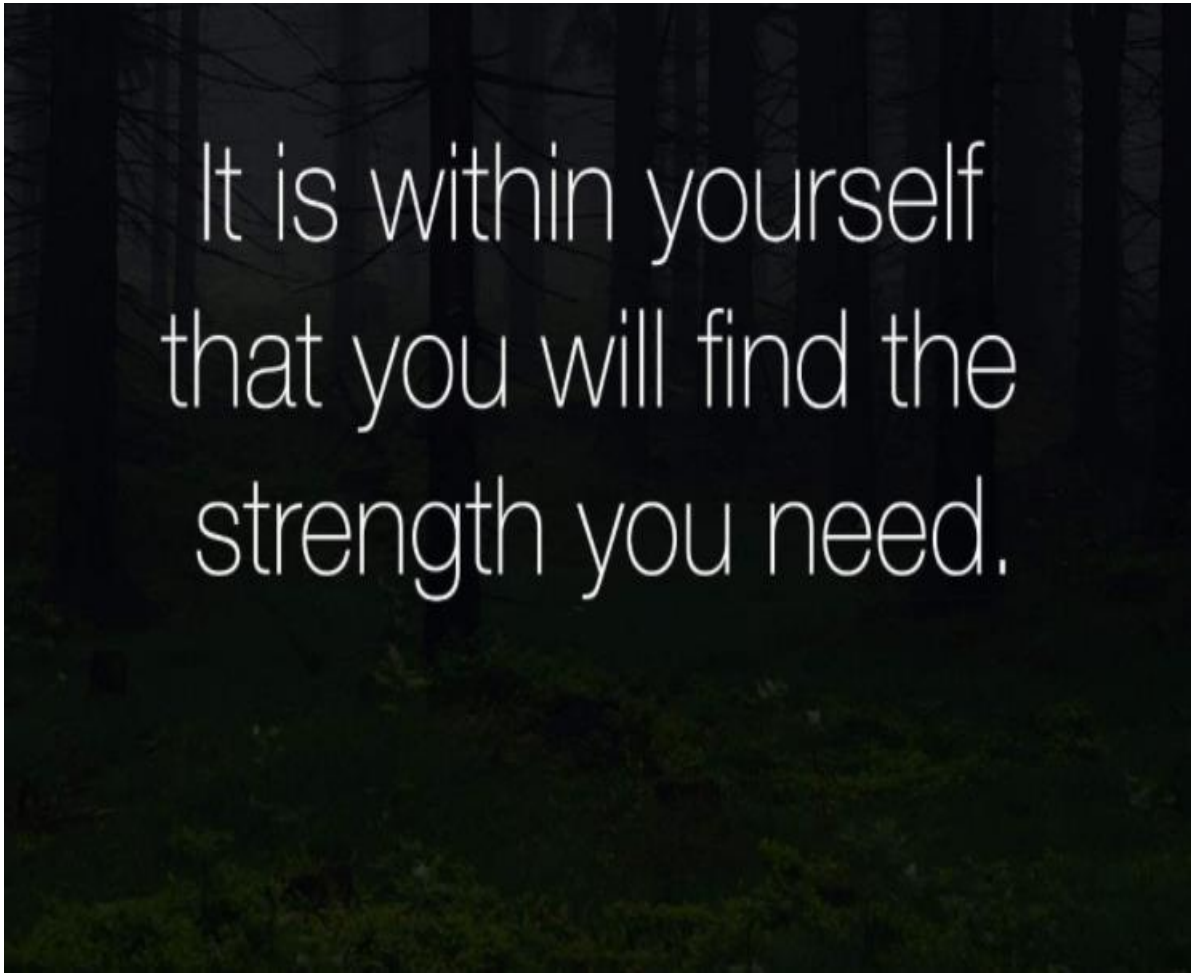

7 ‘Deadly’ sins are especially deadly for doctors

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Medicine and the Seven Deadly Sins:
http://www.mbc.ca.gov/Licensees/Seven_Deadly_Sins/

Lust
Sloth
Envy
Anger
Gluttony
Greed
Pride

8th - Lacking Self / Peer Compassion ?

Disguising our Vulnerability

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We're often profoundly uncomfortable with acknowledging personal vulnerability.

It's drilled into us: Do not show your heart or tears to anyone, ever again,"

Wible said, doctors become "masters of disguise,"
expert at concealing their emotions
begetting further concealment with distress.

This often results in delayed presentation
or presentation *in extremis.*

The Wounded Healer

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For Jung, "a good half of every treatment that probes at all deeply consists in the doctor's examining himself...

it is his own hurt that gives a measure of his power to heal.

To avoid retraumatization, the analyst must have an ongoing relationship with the unconscious,

otherwise he or she could identify with the "healer archetype", and create an inflated ego.[10]

Healers' own wounds could cause damage to those he was attempting to heal.[16]

Jungians warn of the dangers of inflation and splitting in the helping professions,

involving projection of the 'wounded' pole of the archetype onto the patient alone,

with the analyst safely separated off as 'healer'.[12]

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Barriers to care:

Health behaviour of doctors and their doctors

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Self -diagnosis and treatment and self-stigmatisation, especially for mental health problems and occupational stress are significant and well known hazards.

To quote the maxim, physicians who follow the admonition to heal themselves “can be assured that they have a fool for a patient”.

Resort to ineffective 'self-treatment’ for stress, especially resorting alcohol or substance misuse.

For **those who treat Doctors... “all the unders”.**
Under-recognition, under-disclosure, under-assessment, under-diagnosis, under-treatment and under-availability of treatment.

- https://doi.org/10.1192/apt.3.5.290
- https://doi.org/10.1192/apt.9.4.272

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Possible responses

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Looking After Ourselves

Systemic concern

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Awareness ~ Openness ~ Concern

Sustain awareness,
create a climate support
and identify pathways back from seemingly irretrievable situations.

Collegial support is the sine qua non of professional strength

but also recovery from difficulty.

I’m minding Healthcare Campaign May ‘18

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National Office for Suicide Prevention

To **Remember** the many Health Professionals who have died by suicide or in the line of duty.

To **Raise awareness** of physical and mental health issues among Health Professionals, and

To **Reshape the culture** of the Health Care Industry with Hope and Humanity, so that health care workers are given the space to care for each other.

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LOOKING AFTER YOUR WELLBEING IN CONFIDENCE

58: MC - Health and well-being of doctors

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58.1 You have an ethical responsibility to look after your own health and well-being.

You should not treat or prescribe for yourself.

You should have your own general practitioner, who is not a member of your family,

and you should be vaccinated against common communicable diseases.

58.2 If you have an illness which could be a risk to patients or which could seriously impair your judgement,

you must consult an appropriately-qualified professional

and follow their advice. .....

If such a risk exists, you must inform the Medical Council as soon as possible.

Protective factors

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Cultivating the perennials.

Affirmative attitudes and beliefs,
strong and confiding connections
friends and family,
temperance,
awareness of vulnerability,
utilising ordinary care
and our precious sense of irony

Hope is the physician of all despair’

Positive steps

A rest, a change and a fresh take in things
may be often sufficient, but not on your own please!

Many valuable pointers now toward restoring and strengthening professional compassion.

Similarly recognising compassion fatigue or burnout as sufficiently certifiable reasons to take time off work

Reaching out to a colleague in difficulty

To quote the saying '**Leigheas gach dron comhradh' - Conversation cures every sorrow.**

https://doi.org/10.1192/apt.3.5.267

Being hurt hurts and hurts patient care– but, healing that hurt helps very many more.

Help seeking

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The first step to recovery is the hardest, then patient persistence over discouragement inevitably pays off.

Getting help locally is however still no simple matter,
Securing non local expert intervention until recently has been quite difficult for doctors in distress
but important new services have been established

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Working with troubled patients

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Counter-transference in the treatment of suicidal patients

- Chapter:Countertransference in the treatment of suicidal patients Author(s):Mark J Goldblatt and John T Maltsberger DOI:10.1093/med/9780198570059.003.0053

- Countertransference is an inescapable component of all psychotherapy.
- Intense countertransference reactions often occur during the treatment of suicidal patients.

- Lack of awareness of countertransference reactions of malice and aversion may be suicide-inviting.

Working with Healthcare Professional Organisations

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National Office for Suicide Prevention

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Strengthening and making safer procedures

- Medical Council
- The Pharmaceutical Society of Ireland
- Irish Dental Association
- Nursing and Midwifery Board of Ireland

Just remember……..

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Táim buíoch dom siúd a thabharfaidh an onóir dom é a labhairt anseo